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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD13-0027	A. BUILDING _____ B. WING _____	05/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARD	916 FLORAL PL, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from May 29, 2008 through May 30, 2008. A random sample of two residents was selected from a resident population of four women with various degrees of disabilities. In addition, a focused review was conducted of a third resident's prescribed topical creams and ointments. The findings of this survey were based on observations at the group home, interviews with residents and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 002	3600.2 GENERAL PROVISIONS Each GH/MRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GH/MRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The findings include: 1. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1954(c)], as follows:	I 002		

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Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Program Director — (X6) DATE 7/6/08

STATE FORM WOSJ11 If continuation sheet 1 of 12

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I 002	Continued From page 1 a. Cross-refer to I401.1. The GHMRP failed to ensure Resident #2 received Ensure nutritional supplement in accordance with her annual plan and physician's orders. b. Cross-refer to I401.2. The GHMRP failed to ensure Resident #3 received topical creams and lotions in accordance with her annual plan and physician's orders. 2. The facility failed to demonstrate protection of residents' rights to prompt and adequate medical attention [Title 7, Chapter 13, § 7-1305.05, formerly § 6-1986], as follows: a. Cross-refer to I401.3. Resident #1's current health status had not been fully assessed, as she often refused to cooperate with professionals. The facility failed to document aggressive intervention strategies to enlist the resident's cooperation and ensure that potential medical concerns were identified timely (and treated if/when indicated). b. On May 30, 2008, at 11:44 AM, review of Resident #2's dental records revealed that on March 19, 2007, a dentist documented "poor oral health, advanced periodontitis... patient must be assisted with brushing... return 6 months." There was no evidence that she returned in 6 months. At her next documented dental appointment, February 25, 2008, the dentists examined her, documented "heavy calculus." There was no evidence, however, that Resident #2 received treatment that day. There was no evidence that the GHMRP ensured that she was seen by a dentist at the prescribed intervals and/or received treatment for assessed oral health concerns.	I 002 3500.2 I401.3a	Please find attached Copy of court ordered Case Conference and Subsequent evals and mtgs. To date [redacted] has Companion services 4 hours per week to role Play going on appts. and To titrate valium upward from 10-20 mgs on each appointment. Tag I401.3b DDS [redacted] reports submitting preauthorization forms for full mouth scaling in March 2008. At the next perio-dental visit 6/30/08 oral health status, advanced periodontitis, heavy calculus, and new onset of type 2 diabetes will be discuss prior to formulating a revision of the dental treatment plan.	7/8/08

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I 082	Continued From page 2	I 082		
I 082	3809.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to equip bathrooms with the necessary items for each resident's use. The findings include: 1. On May 29, 2008, at 10:50 AM, 1:40 PM and 8:00 PM and on May 30, 2008, at 4:14 PM, there was no hand soap or paper towels in the restroom in the basement. The House Manager stated that residents used this restroom when they were downstairs watching television or playing games. 2. On May 30, 2008, at 4:28 PM, the restroom on the upper floor, nearest the residents' bedrooms was without paper cups for the cup dispenser, soap for hand washing, paper towels and toilet paper. Interview with the direct care staff revealed that these items had not been placed in the bathroom due to concerns with Resident #1's behavior. Further interview, however, revealed that Resident #1 received supervision while using the restroom. It should be noted that at 4:37 PM, Resident #3 was observed to wash her hands in the upstairs restroom. Afterwards, she wiped her hands on her pants (at the hips) to dry them.	I 082	I 082 #1 Please find attached revise facility checklist for both the Lead Counselor and QMRP to monitor weekly to ensure supplies are in place. #2 see I 082 #1.	7/11/08 7/11/08

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I 222	Continued From page 3	I 222		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to document ongoing in-service training for all employees. The findings include: 1. On May 29, 2008, the two direct support staff who were working that evening indicated that they both had begun working in this facility within the past 6 weeks. At 6:40 PM, when asked about the menus they were using at dinner, neither staff could explain what the x's meant or how to utilize the columns to identify specialized diets. Neither staff was aware of the 4 residents' dietary orders, or where to locate them. Resident #1 reportedly was given smaller portions of food, whereas the other 3 residents received the same food items and serving sizes. Neither had received training by the nutritionist. At 6:09 PM, review of the four residents' physician's orders revealed a variety of specialized diets, such as 1800 calorie, 1800 calorie and/or high fiber and/or low fat, low cholesterol, regular or double portions. The most recent documented training on nutrition, meal preparation and/or using the menus was June 14, 2007. [Note: The overnight staff person stated that there had been more recent nutrition training. However, there was no written documentation available to verify who had attended and/or the nature and content of the training. 2. On May 29, 2008, beginning at 7:12 PM, review of staff in-service training records for the period May 2007 - May 9, 2008 revealed	I 222	#1 Ltg 3510.3 Licensed nutritionist conducted specialized diet training on June 18, 2008 at 815 Floral Place N.W. #2 QMRP will conduct monthly in-service training to staff on Basic Assurance Standards, Residents rights, Dignity and Abuse & neglect.	7/11/08

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I 222	Continued From page 4 documentation that on May 11, 2007, June 15, 2007, July 13, 2007 and August 10, 2007, staff had received training on the Basic Assurance Standards, Resident Rights, Dignity, Abuse and Neglect. On June 14, 2007, staff were trained on nutrition/menus and meal preparation. No other in-service training had been documented during the past 12 months. 3. There was no documented evidence of ongoing in-service training in such topics as infection control, dental care/oral hygiene, or behavior management plans, among others. When interviewed on May 30, 2008, beginning at 7:37 AM, an overnight staff person indicated that she had attended two trainings by the nutritionist in "recent" months. Neither training, however, had been documented in the GHMRP in-service training log book. The facility's Qualified Mental Retardation Professional (QMRP) reportedly had her last day of employment on the day before the survey began. A QMRP for another facility operated by this agency was made available to facilitate the survey process. On May 30, 2008, at 8:28 AM, the other QMRP stated that she and the former QMRP had presented training jointly to staff from both facilities. She further indicated that nurses had presented health-related training and she confirmed that the nutritionist had provided recent in-service. The QMRP looked at the in-service log book and acknowledged that documentation was not available for verification. She offered to secure additional staff training records, however, no additional information was presented before the survey ended at 5:50 PM later that day.	I 222	Tag 3510.3 Licensed nutritionist conducted specialized diet training on June 18, 2008 at 815 Floral Place N.W.	

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I 227	Continued From page 5	I 227		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on interview and review of personnel records that were made available, the GHMRP failed to document that all staff had received training in first aid and/or certification in Cardiopulmonary Resuscitation (CPR), in accordance with agency policies. The finding includes: On May 29, 2008, review of personnel files and staff in-service training records, beginning at 12:50 PM and 7:12 PM respectively, revealed no documented evidence of CPR certification for the LPN who was observed administering medications to residents earlier that morning.	I 227	C. Please find attached Copy of LPN's CPR certification.	7/8/08
I 401	3020.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provided diagnosis, evaluation, treatment services and necessary follow up service to prevent deterioration or further loss of functioning for each resident in the facility, for	I 401		

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I 401	Continued From page 6 three of the four residents. (Residents #1, #2 and #3) The findings include: 1. There was no evidence that Resident #2 received Ensure nutritional supplement, in accordance with her annual plan and physician's orders, as follows: On May 29, 2008, at 6:09 PM, Resident #2's dietary orders included "Ensure every day for nutritional supplement." She had not been observed receiving Ensure that day. Direct support staff that evening said none of the four residents received Ensure supplement. The overnight staff person was interviewed the next morning, May 30, 2008. She too did not think any of the four ladies received a liquid nutritional supplement. At 11:27 AM, the RN also was unaware that Resident #2 was to receive Ensure daily. She looked at the POs and confirmed that there was the order since 2005. The RN further indicated that Ensure had not been purchased. 2. There was no evidence that Resident #3 received topical creams and lotions in accordance with her annual plan and physician's orders, as follows: The survey started at 8:52 AM on May 29, 2008, at which time Resident #3 was observed with white drool dribbled down her chin. At 7:13 AM, a medication nurse was observed administering her medications. He handed to her a small cup into which he had squeezed some Ammonium Lactate 12% cream just moments earlier. Resident #3 took the cup and promptly left the room. When queried, the nurse said that she and staff had been trained on how, where, when etc.	I 401	Tag I401-1 Resident #2 was ordered ensure in 2005 as a nutritional supplement in case of decreased PO intake or weight loss than body requirements. Order for ensure discontinued as of June 6, 2008. Resident #2's nutritional status will continued to be monitored by the nutritionist quarterly or as clinically indicated. Tag 1401 Topical medication application training is given quarterly (last date 4/16/08) the next training and required demonstration is scheduled for July 3, 2008. ([redacted])	

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WARD	615 FLORAL PL, NW WASHINGTON, DC 20012

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1401	Continued From page 7 to apply cream. At 8:30 AM, review of Resident #3's physician's orders revealed that in addition to the Ammonium Lactate 12% cream, her POs included 3 other topicals: - Econazole Nitrate 1% cream apply to hands twice daily; - Hydrocortisone Valerate 0.2% ointment apply to face twice daily; and, - Vitamin A & D ointment apply to lips every day as as needed for drooling." a. Resident #3 was not observed receiving any Econazole Nitrate cream, Hydrocortisone Valerate ointment, or Vitamin A & D lip ointment, even though drool had been observed on her mouth and chin that morning. b. At 10:37 AM, review of the resident's "Daily Topical and Creams Application Log" sheet for May 2008 revealed significant gaps in documentation, as follows: 1) Staff had documented applying the Ammonium Lactate cream once daily, instead of twice daily, on 7 out of 28 days (5/3, 5/4, 5/6,5/7, 5/9, 5/12 and 5/16); 2) Staff failed to document application of any Ammonium Lactate cream on 19 out of 28 days (5/1, 5/2, 5/8, 5/10, 5/11, 5/13,5/14, 5/15, and 5/17-5/28); 3) Staff documented applying the Econazole Nitrate cream once daily, instead of twice daily, on 4 days out of 28 (5/3, 5/4, 5/7, and 5/9); 4) Staff failed to document application of any Econazole Nitrate cream on 20 out of 28 days (5/1, 5/2, 5/8, 5/6, 5/10, 5/11, 5/13,5/14, 5/15, and 5/17-5/28);	1401	Tag 1401-b1 Direct care staff is no longer responsible for documentation of topical medication application. Documentation of topical medication application is located on MAR for each individual as of June 20, 2008. Trained medication employees or licensed nursing personnel will document topical applications. Topical medication will locate on the treatment portion of the MAR by pharmacy personnel. In order to be proactive and improve customer service to individuals going home for family visits.	7/8/08
		#2	See 1401-b1.	7/8/08
		#3	See 1401-b1.	7/8/08
		#4	See 1401-b1.	7/8/08

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I 401	Continued From page 8 5) The topicals sheet did not reflect Resident #3's order for Hydrocortisone Valerate 0.2% ointment, and there was no evidence that this medication had been applied; and, 6) The topicals sheet did not reflect the Vitamin A & D ointment, and there was no evidence that this medication had been applied as needed. c. On May 29, 2008, at 6:50 PM, inspection of the medication cabinet revealed no evidence that Hydrocortisone Valerate ointment or Vitamin A & D lip ointments were available in the facility. d. An empty tube of Econazole Nitrate cream was located. At 6:55 PM, the medication nurse telephoned the RN to ask about the 3 ointments. The RN conveyed that Resident #3 reportedly had left the tubes at her family home during a recent home visit. e. On May 30, 2008, at 4:36 PM, a crack was observed in Resident #3's lower lip. There was a small amount of blood in the crack. Resident #3 had not received Vitamin A & D ointment in accordance with her physician's orders and as noted above, there was no evidence that the ointment was available for use in the facility that day. There was no evidence that the GHMRP had established a system to ensure that Resident #3 had available for use, and received all topical creams, lotions and ointments in accordance with physician's orders. 3. The GHMRP failed to ensure that Resident #1 received medical evaluations and treatments, as follows:	I 401	#5 See I401-b1.	7/8/08
			#6 See I401-b1.	7/8/08

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I 401	Continued From page 9 a. On May 29, 2008, at 7:34 AM, Resident #1 was observed resisting the nurse's attempts to administer prescribed eye drops during the morning medication pass. She remained non-compliant and the eye drops were not effectively administered. b. The medication nurse indicated that she had a history of refusing medical care and treatments. The facility's Registered Nurse (RN) was interviewed later that morning. At approximately 9:45 AM, she confirmed that Resident #1 had a history of non-compliance with medical personnel. According to the RN, the resident often refused to get off the facility van when taken to appointments. She acknowledged that the resident was in need of many health screenings and assessment updates. c. On May 30, 2008, beginning at 8:53 AM, review of Resident #1's medical record revealed that on March 13, 2008, the House Manager had documented that the resident "refused to get out of the van" for a dental appointment. The record reflected numerous other appointments that had been cancelled due to Resident #1's non-compliance. d. Resident #1's physician's orders included: - "Lorazepam 1 mg tab (Ativan), 3 tabs (3 mg) by mouth one hour before procedure." and - "Haldol 5 mg tab 1/2 hr to 1 hr prior to all medical appointments." However, her Medication Administration Records (MARs) for the period beginning February 1, 2008 to date showed no evidence that she was ever administered a sedative prior to medical appointments, including her March 13, 2008 dental appointment. [Note: A request was made		Tag 1401-a Resident #1's resistance eye drop instillation resulted in scheduling an opth appointment to discuss methods of increasing compliance or change in medical treatment plan. (7/23/08) Tag 1401.3a Ward and Ward has aggressively sought intervention for resident #1 however due to her lengthy history of non-compliance with medical appointments her current health status remains unclear. Documentation indicating the primary physician, substitute health care decision maker, residential provider, and psychiatrist continue to actively seek resolution was presented during this review. 6/25/08 [redacted] under the auspice of DDS conducted a review by behaviorist [redacted] of the health challenges presented by resident #1. A thirty day monitoring of compliance with medical appointments and or health care will begin 6/30/08. All new team approved interventions Will be in place by 6/30/08. Tag 1401.3b DDS [redacted] reports submitting preauthorization forms for full mouth scaling in March 2008. At the next perio-dental visit 6/30/08 oral health status, advanced periodontitis, heavy calculus, and new onset of type 2 diabetes will be discuss prior to formulating a revision of the dental treatment plan.	

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I 401	Continued From page 10 to see Resident #1's MARs for months preceding February 2008; however, no additional information was presented before the survey ended at 8:50 PM that evening.] e. There was no evidence that GH/MRP nurses sought clarification from the primary care physician regarding the existing orders. Taking both the Ativan and Haldol sedatives concurrently would have a highly-sedative effect. As written, the orders were not clear whether she should receive just one, or both. f. On May 30, 2008, beginning at 10:00 AM, review of Resident #1's nursing monthly reports (from September 2007 onward) and QMRP monthly reports (from May 2007 onwards) showed no evidence that they had monitored the implementation of all aspects of the resident's behavior management plan, which included strategies for enlisting the resident's compliance with medical appointments. g. A newly-appointed surrogate healthcare decision-maker reportedly had expressed concern that Resident #1 was in need of many health screenings and assessment updates. Members of her interdisciplinary team subsequently met on March 20, 2008 to discuss the client's behavioral and medical needs. There was no evidence that the team sought evidence that all aspects of the resident's behavior management plan, which included strategies for enlisting the resident's compliance with medical appointments, had been implemented as written. h. An April 7, 2008 Psychiatric Assessment included a recommended: "sedation for medical appointments, titrate dosages upward as necessary to appropriate level of compliance	I 401	Tag 1401-e-f Sedation order for Resident #1 was clarified to reflect the discontinuance of Haldol and Ativan 6/1/08. New order calls for Valium 10mg one-half prior to appointment. RN will ensure health care guardian is notified prior to any scheduled appointment and consents to sedative use. RN will verify documentation of administration of prescribed sedative agent on medication control sheet (pharmacy issued) and MAR. Tag 1401-f Non-compliance interventions approved by team and health care guardian will be monitored on monthly health and wellness note. HMCP will be updated to include new interventions for non-compliance as discovered I401 G. See 1002. I401 H. See 1002.	7-8-08 7/8/08

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I 401	Continued From page 11 (recommend Valium 10 mg to 20 mg).* There was no documented evidence, however, that the facility had implemented less-restrictive techniques, as outlined by the consulting psychologist (examples "peer supports, playful cossing"). According to a Nursing Monthly Report dated March 30, 2008, the surrogate healthcare decision-maker "suggested exploring one-on-one staffing as a means of increasing compliance. There was no evidence that the GHMRP sought additional staffing supports.	I 401		